Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 4-9-01 and 4-19-01.
   b. The request was received on 3-29-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFAs
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFAs
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. No Carrier sign sheet was noted in the dispute packet. Dispute Resolution Information System Case Activity Log, Sequence #7, indicates that additional information was submitted to the insurance carrier but the date submitted was not noted on the log. All information in the dispute packet will be reviewed.

4. Dispute Resolution Information System Case Activity Log, Sequence #7, is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Position statement taken from table of disputed services:
   "We feel that we are due full reimbursements for the durable medical equipment we billed this patient with. This equipment was billed at a Fair & Reasonable rate following TWCC fee guidelines. The carrier has still denied us full reimbursement on this equipment after we have provided supporting documents showing cost and medical necessity for this equipment. We are now requesting full reimbursement w/interest."

2. Respondent: Letter dated 6-10-02:
"It appears payment of $4,059.10 was recommended based on fair and reasonable as defined per the Texas 2001 Medicare DME fee schedule, plus 20 percent."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 4-9-01 and 4-19-01.

2. The carrier denied the billed services as reflected by the EOBs as, "130 – Payment recommendation based on fair and reasonable which ___' has defined as the Texas 2001 Medicare DME Fee Schedule plus 20%; M – Payment recommendation based on fair and reasonable which ___ has defined as the Texas 2001 Medicare DME Fee Schedule plus 20%; 005 – The amount charged exceeds the maximum usual and customary fee for the same service(s) in the same geographic area."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MAR$	REFERENCE	RATIONALE:
4-9-01	E0748-NU	$5,000.00	$4,023.10	130, M	DOP	MFG GI (VIII) (A); HCPCS descriptor	This modifier is not recognized in the Commission's '96 MFG. For this reason, MRD is unable to determine proper reimbursement for the services in dispute.
4-9-01	E1399	$40.00	$-0- pursuant to the table of disputed services	No denial	DOP	Rule 133.307 (g) (3) (D), (E);	EOB dated 6-15-01 indicates that this HCPCS code was recommended for payment with no denial code. No further action can be taken, by Medical Review, on this code as payment has been recommended. If no payment was received contact Compliance and Practices.
4-9-01	97139 TN	$185.00	$-0-	M	DOP	CPT descriptor; MFG (I) (C) (1) (q); Rule 133.307 (g) (3) (D); 133.304 (i); TWCC Importance of Proper Billing listed in the Table of Contents of the MFG;	The descriptor for CPT code 97139 as "**DOP** unlisted therapeutic procedure, specify". The MFG states "when billing for the following services, identify each with the appropriate code and alpha modifier as indicated below:… q. 97139-TN TENS application for trial basis (includes supplies/training)". The provider lists "97139-TN" as "TRAINING/FITTING FEES BONE GROWTH STIMULATOR". According to TWCC proper coding of services is essential for proper reimbursement. The provider billed a CPT code which does not describe the procedure billed on the HCFA submitted by the provider. Therefore, **no additional** reimbursement is recommended.

4-9-01	EO244	$ 103.00	$ 36.00	130, M	DOP	Rule 133.307 (g) (3) (D), (E); Section 413.011 (d); HCPCS descriptor	Section 413.011 states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf." Per Rule 133.307 (g) (3) (D), the provider failed to support their position that the fees charged were fair and reasonable as required by Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The provider has failed to discuss, demonstrate and/or justify that the payment being sought is fair and reasonable. Therefore, **no additional** reimbursement is recommended.
Totals		$5,328.00	$4,059.00				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 18th day of February 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll